

**ASBESTOS EXPOSURE
PART I - INITIAL MEDICAL QUESTIONNAIRE**

IDENTIFICATION

1. NAME (Last, First, Middle Initial)		2. SOCIAL SECURITY NO. (1 - 9)	3. CLOCK NO. (10 - 15)	4. PRESENT OCCUPATION	
5. NAME OF PLANT		6. STREET ADDRESS OF PLANT		7. PLANT CITY, STATE AND ZIP CODE	
8. TELEPHONE NO. (Include area code)	9. NAME OF INTERVIEWER		10. DATE OF INTERVIEW (16 - 21) (YYYYMMDD)	11. DATE OF BIRTH (22 - 29) (YYYYMMDD)	12. PLACE OF BIRTH
13. SEX (X one) ☐ a. MALE ☐ b. FEMALE	14. MARITAL STATUS (X one) ☐ a. SINGLE ☐ b. MARRIED ☐ c. WIDOWED ☐ d. DIVORCED/SEPARATED		15. RACE (X one) ☐ a. WHITE ☐ b. BLACK ☐ c. ASIAN ☐ d. HISPANIC ☐ e. INDIAN ☐ f. OTHER		16. HIGHEST GRADE COMPLETED IN SCHOOL

MEDICAL DATA

17. OCCUPATIONAL HISTORY			Yes	No	N/A	21. DID YOU HAVE ANY LUNG TROUBLE BEFORE THE AGE OF 16?			Yes	No	N/A		
a. HAVE YOU EVER WORKED FULL TIME (30 hours per week or more) FOR SIX MONTHS OR MORE?			☐	☐	☐	22. HAVE YOU EVER HAD ANY OF THE FOLLOWING?			☐	☐	☐		
b. IF YES, HAVE YOU EVER WORKED FOR A YEAR OR MORE IN ANY DUSTY JOB? *If Yes, complete (1) - (3).			☐	☐	☐	a. ATTACKS OF BRONCHITIS * If yes, complete (1) and (2).			☐	☐	☐		
(1) Specify Job/Industry	(2) Total years worked	(3) Dust Exposure (X one) ☐ MILD ☐ MODERATE ☐ SEVERE	☐	☐	☐	(1) Age at first attack (2) Was it confirmed by a doctor?			☐	☐	☐		
c. HAVE YOU EVER BEEN EXPOSED TO GAS OR CHEMICAL FUMES IN YOUR WORK? *If Yes, complete (1) - (3).			☐	☐	☐	b. ATTACKS OF PNEUMONIA (Include bronchopneumonia) *If yes, complete (1) and (2)			☐	☐	☐		
(1) Specify Job/ Industry	(2) Total years worked	(3) Exposure (X one) ☐ MILD ☐ MODERATE ☐ SEVERE	☐	☐	☐	(1) Age at first attack (2) Was it confirmed by a doctor?			☐	☐	☐		
d. WHAT HAS BEEN YOUR USUAL OCCUPATION - THE ONE YOU HAVE WORKED AT THE LONGEST?			☐	☐	☐	c. HAY FEVER * If yes, complete (1) and (2).			☐	☐	☐		
(1) Job/Occupation		(2) Number of years employed in this occupation		☐	☐	☐	(1) Age at first attack (2) Was it confirmed by a doctor?			☐	☐	☐	
(3) Position/Job Title		(4) Business, Field or Industry		☐	☐	☐	23. HAVE YOU EVER HAD CHRONIC BRONCHITIS?			☐	☐	☐	
e. HAVE YOU EVER WORKED (X Yes or No and specify years worked, e.g. 1960 - 1969.)			Years Worked		☐	☐	☐	a. IF YES, DO YOU STILL HAVE IT?			☐	☐	☐
(1) In a mine			☐	☐	☐	b. WAS IT CONFIRMED BY A DOCTOR?			☐	☐	☐		
(2) In a quarry			☐	☐	☐	c. AT WHAT AGE DID IT START? (List age)			☐	☐	☐		
(3) In a foundry			☐	☐	☐	d. IF YOU NO LONGER HAVE IT, AT WHAT AGE DID IT STOP? (List age)			☐	☐	☐		
(4) In a pottery			☐	☐	☐	26. HAVE YOU EVER HAD:			☐	☐	☐		
(5) In a cotton, flax or hemp mill			☐	☐	☐	a. ANY OTHER CHEST ILLNESSES *If yes, please specify.			☐	☐	☐		
(6) With asbestos			☐	☐	☐	b. ANY CHEST OPERATIONS *If yes, please specify.			☐	☐	☐		
18. MEDICAL HISTORY			☐	☐	☐	c. ANY CHEST INJURIES *If yes, please specify.			☐	☐	☐		
a. DO YOU CONSIDER YOURSELF TO BE IN GOOD HEALTH? *If No, state reason.			☐	☐	☐	27. HEART TROUBLE			☐	☐	☐		
b. HAVE YOU ANY DEFECT OF VISION? *If Yes, state nature of defect.			☐	☐	☐	a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HEART TROUBLE?			☐	☐	☐		
c. HAVE YOU ANY HEARING DEFECT? *If Yes, state nature of defect.			☐	☐	☐	b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HEART TROUBLE IN THE PAST TEN YEARS?			☐	☐	☐		
d. ARE YOU SUFFERING FROM OR HAVE YOU EVER SUFFERED FROM			☐	☐	☐	28. HIGH BLOOD PRESSURE			☐	☐	☐		
(1) Epilepsy (Or fits, seizures or convulsions)			☐	☐	☐	a. HAS A DOCTOR EVER TOLD YOU THAT YOU HAD HIGH BLOOD PRESSURE (Hypertension)?			☐	☐	☐		
(2) Rheumatic Fever			☐	☐	☐	b. IF YES, HAVE YOU EVER HAD TREATMENT FOR HIGH BLOOD PRESSURE IN THE PAST TEN YEARS?			☐	☐	☐		
(3) Kidney Disease			☐	☐	☐	29. WHEN DID YOU LAST HAVE YOUR CHEST X-RAYED? (Year)			☐	☐	☐		
(4) Bladder Disease			☐	☐	☐	30. CHEST X-RAY			☐	☐	☐		
(5) Diabetes			☐	☐	☐	a. WHERE DID YOU LAST HAVE YOUR CHEST X-RAYED? (if known)			☐	☐	☐		
(6) Jaundice			☐	☐	☐	b. WHAT WAS THE OUTCOME?			☐	☐	☐		
19. IF YOU GET A COLD, DOES IT USUALLY GO TO YOUR CHEST? (Usually means more than 1/2 of the time)*Don't get colds			☐	☐	☐	c. IN THE LAST THREE YEARS, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? (List number)			☐	☐	☐		
20. CHEST ILLNESSES			☐	☐	☐	a. DURING THE PAST THREE YEARS, HAVE YOU HAD ANY CHEST ILLNESSES THAT HAVE KEPT YOU OFF WORK, INDOORS AT HOME, OR IN BED?			☐	☐	☐		
b. IF YES, DID YOU PRODUCE PHLEGM WITH ANY OF THESE ILLNESSES?			☐	☐	☐	c. IN THE LAST THREE YEARS, HOW MANY SUCH ILLNESSES WITH INCREASED PHLEGM DID YOU HAVE WHICH LASTED A WEEK OR MORE? (List number)			☐	☐	☐		

MEDICAL DATA (Continued)

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